STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	08/26/2011

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CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

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F0000	This visit was for the Investigation of Complaints IN00094823, IN00095103, IN00095216, and IN00095326. This visit resulted in a partially extended survey-immediate jeopardy. Complaint IN00094823 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Complaint IN00095103 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F514. Complaint IN00095216 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Complaint IN00095326 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 15, 16, 17, 2011 Extended survey dates: August 18, 19, 22, 23, 24, 25, 26, 2011 Facility number: 000195 Provider number: 155298 AIM number: 100267690	F0000	Cambridge Manor Healthcare and Rehabilitation's preparation and execution of this Plan of Correction in general, or any corrective action does not constitute an admission or agreement by the facility of the facts alleged or the conclusions set forth in the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Survey team: Charles Stevenson RN Census bed type: SNF/ NF: 90 Total: 90 Census payor type: Medicare: 4 Medicaid: 66 Other: 20 Total: 90 Sample: 3 Supplemental sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/02/11 by Suzanne Williams, RN			
F0223 SS=J	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to protect a totally dependent resident (Resident B) from abuse (sexually inappropriate contact) by a facility volunteer (Volunteer #3). The	F0223	Element#1: What corrective actions will be accomplished for those residents found to have been affected by the deficient practices?It is the policy of this facility to see that each resident's	09/25/2011

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	facility failed to provide adequate abuse training, failed to provide adequate supervision to prevent abuse, and failed to ensure facility staff (Activities Aid #1) promptly provided for resident safety when made aware of a potentially abusive situation, for 1 of 3 residents reviewed for potential abuse in a sample of 3. The facility also failed to fully investigate, report, and provide protection for an allegation of staff (CNA #6) verbal abuse of a cognitively impaired, dependent resident (Resident I), for 1 of 2 residents reviewed for potential abuse in a supplemental sample of 6. The immediate jeopardy began on 8/10/11 when Volunteer #3 had inappropriate sexual contact with Resident #B. The Administrator, Vice President of Operations, and Activities Director were notified of the immediate jeopardy on 8/16/11 at 2:15 p.m. The Immediate Jeopardy was removed on 8/17/11 based on the facility's plan of correction. On 8/23/11 at 2:30 p.m. the removal of the immediate jeopardy was rescinded based on the facility's failure to demonstrate that an effective plan was in place and being followed. The immediate jeopardy remained in effect beginning 8/10/11. The immediate jeopardy was removed on 8/23/11, but the facility remained out of compliance at the level of isolated, no		right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion are upheld and enforced.Resident B is kept free from any type of abuse as stated above.Volunteer #3 is permanently banned from the facility and the facility property.Residents C and I are kept free from any type of abuse as stated above.Activity assistant #1 has been further educated, inserviced and counseled as to the exact steps that need to be taken immediately upon receiving of information or observing any action that even suggests the possibility of abuse or alleged abuse. This includes but is not limited to immediately providing for the residents safety removing any threat and reporting to the administrator so all protocols can commence, including full assessment of the resident and reporting to all required parties. The resident's physician and family must be notified and consulted immediately. In addition, the appropriate state agency such as APS (Adult protective services), ombudsman, police, licensing or certification agencies will also be informed of abusive situations.CNA #6 no longer works at the facility. All incidents of abuse or alleged abuse are immediately reported to the administrator. All incidents are thoroughly investigated, including immediate interviews of	

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	actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings Include: 1. The record of Resident B was reviewed on 8/16/11 at 3:00 p.m. Diagnoses included, but were not limited to, hypertension, seizure disorder, aphasia, anoxic brain injury, depression, coronary artery disease, and bipolar disorder. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/20/11 indicated Resident B was totally dependent on staff for bed mobility, locomotion, eating, and personal hygiene. An untitled document received from the Administrator on 8/15/11 at 1:15 P.M. and identified as a recapitulation of events related to the investigation of an incident of potential abuse of Resident B on 8/10/11 indicated: "At approximately 1:15 PM on 8/10/2011 the Administrator was approached by (Name of Activity Director)...The Activity Director and her assistant told the Administrator that a resident (Resident C) had made gestures and pointed to indicate that something was wrong with		any person(s) who might have a degree of knowledge of what has or may have happened (any potential witnesses). The administrator will spearhead this carrying out of protocol.The volunteer program is currently suspended pending revision, including photo ID requirements, sign-in/sign-out protocols, training, inservicing on abuse and resident rights, and reference checking.Element #2: How other residents having the potential to be affected by the same deficiency will be identified and what corrective action(s) will be taken.All residents have the potential to be affected by this finding. Following both of the afore mentioned instances of abuse or alleged abuse involving resident B and resident I, facility wide audits were conducted to be sure no other residents had experienced similar incidents that were not properly addressed. Now going forward, social services staff will monitor 10 residents per week (5 on each floor) to check for any unacceptable treatment or unkind words being used towards them. Any findings will be immediately reported to the administrator and all protocols will be followed as per facility policy and state and federal regulations. This monitoring will be ongoing.Element #3: What measures will be put into place or what systematic changes will be	

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	(Resident C's) roommate... (Resident C) is alert and oriented to person and place, but confused to time (day, month, year). Speech is unclear, but able to answer yes/no questions. Able to understand others. Decision making is consistent and reasonable. At this time (Resident C) was trying to indicate through pointing and gestures about her roommate, and activity volunteer (Volunteer #3) walked by. (Name of Volunteer #3) walked by... As (Volunteer #3) walked by (Resident C) seemed to become more excited. She seemed to be indicating that her concern involved (Volunteer #3). (Resident C) then placed her leg on her roommate (Resident B)...Since (Resident C) was linking (Volunteer #3) to (Resident B), (Activity Aid #1) went to get her supervisor to try to figure out what (Resident C) was trying to convey... When (Activity Aid #1's) supervisor arrived, they both took (Volunteer #3) aside and asked him if he had been near (Resident B) today. He said he had. They asked what type of interaction he had with (Resident B). (Volunteer #1) stated he was talking with her because she was crying and he wanted to comfort her. When		made to ensure that the deficient practice does not recur.At an all staff inservice held 9/20/2011 and 9/22/2011 the following was reviewed:A. Abuse 1. Abuse policy 2. Types of abuse 3. Step by step actions to be taken when a staff member observes or hears of an abuse or alleged abuse 4. Question/AnswersAny staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined up to and including termination. The facility has zero tolerance for abuse or failure to report abuse or alleged abuse.Element #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.At the monthly Quality Assurance meetings, any reports of abuse or alleged abuse will be reviewed to be certain all of the proper protocols are followed, including but not limited to, providing immediate safety to the resident, removing the threat and reporting to the administrator. Also, seeing all the proper investigation, interviewing of witnesses and reporting was done. Any concerns will be immediately addressed by the administrator.	

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	asked what he had done to comfort her, he stated he kissed her on the cheeks and lips. He also stated he rubbed her thigh and her private area... When the Administrator interviewed (Volunteer #3) (he) admitted to kissing (Resident B's) cheeks, lips, and touching her thigh and private area...(Volunteer #3) was asked to stay seated and his aunt was called to pick him up...The allegations were explained to her...Administrator collected name badge, and key to sweet shop... The Administrator had advanced to (Resident B's) room...When asked by the Administrator if (Volunteer #3) had been inappropriate with her, she said 'yes.' When asked if (Volunteer #3) kissed or touched her, she said no he had not. She stated he had pushed her wheelchair too hard. (Resident B) was the assessed head to toe by the ADON (Assistant Director of Nursing) and Nurse Practitioner...the Nurse Practitioner asked her if (Volunteer #3) had touched her breast. She said 'yes'. When asked if he had touched her underneath her pants, she said 'Yes'. (Resident B) was sent to the ER for an exam and a rape kit. Her family was			

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	notified..." During an interview on 8/15/11 at 1:30 p.m., Activity Aid #1 indicated that during her communication with Resident C, which she indicated occurred at 11:50 a.m. in the 3rd floor dining room, she saw Volunteer #3 heading toward the pantry area, which is adjacent to the dining room.. She did not observe if he left the area. Residents B and C were sitting at the first table directly in front of the entrance to the dining room. This table is in clear view of the 3rd floor nurse's station. After determining that Resident C was communicating a concern involving Resident B and Volunteer #3, she then went to the activity director's office to report the incident. When she could not find the Activity Director she went to lunch. She indicated she did not inform anyone of the incident, and did not remove Resident B from the area. She indicated she was uncertain where Volunteer #3 had gone. When she meet the Activity Director in the employee break room, she indicated she had something to tell her. At the Activity Director's request, she accompanied her to her car while the Activity Director got her lunch and described the incident. They then returned to the building. During an interview with the Activity			

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	Director on 8/15/11 at 3:00 p.m., she indicated Resident B had participated in an activity which ended at 11:50 a.m. She indicated nursing staff took Resident B to the dining room. She indicated Activity Aid #1 told her of the incident involving Volunteer #3 and Resident B at 12:45 p.m. She then found Volunteer #3 in the break room and took him to the lobby area of the facility to interview him. She indicated she could not confirm where Volunteer #3 was between the time of the incident and when she found him in the break room. After confirming the facts of the incident, she called the Administrator and met with him. He then isolated Volunteer #3 in his office. The Activity Director indicated the facility used "occasional" volunteers, which she indicated meant they volunteered less than 8 hours per week. She indicated these volunteers had no background checks done, no PPD records were required, and they received no training or instruction in facility policies, including abuse and resident's rights. She provided a list of 10 volunteers who met this criteria. During a telephone interview on 8/16/11 at 11:45 a.m., Volunteer #5 indicated he had been volunteering at the facility for 5 years, and came twice per week. He indicated he gave residents communion, read bible verses, and talked and prayed			

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	with the residents. He indicated he had never received any training or information about facility policy concerning resident rights or abuse protocols. He indicated he had not received any training of any kind from the facility. Volunteer #6 was interviewed by phone on 8/16/11 at 11:50. He indicated he had been volunteering for 5 years and came to the facility "all the time." He stated "They all know me so I don't need to sign in." On 8/15/11 at 1:15 p.m. the Administrator provided a packet of documents which he indicated to be the facility's complete records for Volunteer #3. There was a criminal background check dated 11/13/06 which was negative. There were 2 reference check forms which had not been completed. There was a 6 question "Abuse and Neglect Pre/Post Test" dated 5/04/09 which was signed as "Assisted by (Name of Activity Director)". There was no other indication of any training or education on resident's rights or abuse policies and protocols. During an interview with the Administrator on 8/16/11 at 3:20 p.m. he indicated he had originally believed the incident between Resident B and Volunteer#3 had occurred in the resident's room, but was later informed it had			

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	occurred in the dining room. He indicated he had not identified or interviewed any potential witnesses to the incident, including residents and staff who were in the area. He indicated that because Volunteer #3 had confirmed the incident, he didn't think further investigation was warranted. 2. The record of Resident I was reviewed on 8/23/11 at 10:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, aspiration pneumonia, Alzheimer's Disease, congestive heart failure, hypertension, and depression. A quarterly Minimum Data Set (M.D.S.) assessment dated 7/07/11 indicated Resident I was cognitively impaired and required staff assistance with all activities of daily living. An untitled document received from the Administrator on 8/23/11 at 9:35 a.m. and identified as a recapitulation of his investigation of an allegation of staff verbal abuse of a resident indicated: On Thursday, 8/18/2011, at approximately 11:45 am, received a very strange voicemail...made an allegation about a CNA (first name of CNA #6)...The			

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	allegation was that (first name of CNA #6) had told a resident 'shut up white B...'...I asked (Social Services Director) to listen to the message...Approximately 11:50 a.m. (Social Services Director) and I went upstairs to find (CNA #6)...We were informed she was on lunch (erroneous information)...we checked to see where (Resident I) was located to ensure her safety...We then checked to see if she would be interviewable...(she) has a secondary diagnosis of Alzheimer's...we then interviewed (LPN #7)...she stated that...she did not work the previous day...We then asked (LPN #8)...the same question we asked (LPN #7)...(she) stated she did work, but did not receive any concerns involving either individual in question. She did state (CNA #6) was in the Savoy dining hall (with resident I)...11:57, asked (CNA #6) to join me, as I had some questions for her...I asked her if there were any type of negative interactions with any residents, to which she emphatically denied...In previous conversations with my Director of Nursing...she had shared (CNA #6) has had a history of being somewhat insubordinate and loud with her supervisors...At 12:02, I was done interviewing (CNA #6), so I gave her a few coupons to go stay in the break room until (Social Services #9) could speak with (Resident I)...Trying to identify more			

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	people to interview, I had (SS #9 and A.D.O.N. #10) listen to the message to see if they could recognize the voice. Nether of them could...As no one could identify anyone else to interview, and there were zero indications there was any validity to this random phone call, I returned the only person we could suspect of this back to work at about 12:31." The personnel file of CNA #6 was reviewed on 8/23/11 at 11:00 a.m. It included, but was not limited to: An "Evaluation of Employee" form dated 5/22/11 indicated: "Remarks: Needs to modulate tone of voice at times perceived loud (symbol for "and") hostile.." A "Notice of Disciplinary Action" form dated 6/07/11 indicated "This is to inform you that your performance and /or conduct has been recognized as described. This will become a part of your personnel file...loud verbally, inappropriate language (X 2 addressed)..." During an interview on 8/22/11 at 4:00 p.m. the Administrator indicated that the allegation described above had not been reported to the State agency, that no additional investigation had been done, that there was no additional documentation of staff or resident			

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	interviews, and that CNA #6 continued to work in the facility. During an interview with the Administrator on 8/25/11 at 10:45 p.m. he indicated that on further investigation of this incident the allegation of verbal abuse could not be disproven and that CNA #6 had been suspended with termination anticipated. 3. An undated facility document titled "Volunteer Guidelines" received from the Administrator on 8/16/11 at 8:45 a.m. and identified as a current facility policy indicated: "4. Abide by all 'Rules' and policies explained to you including Abuse Policy... Don'ts: (sic) 1. Never have physical contact with a Resident other than minimal contact with hands as in manicure/card games/helping with writing." An undated facility policy titled "Abuse Protection and Response Policy" received from the Administrator on 8/15/11 at 1:15 p.m. and identified as a current facility policy indicated: "Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including			

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	staff, patients, consultants and volunteers, family members or legal guardians, friends or any individual...The center administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority. Definitions: 1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish... 4. Sexual abuse: includes but is not limited to sexual harassment, sexual coercion, or sexual assault... Prevention issues: 1. Policy: the center will provide supervision and support services designed to reduce the likelihood of abusive behaviors... Identification Issues: A. Policy: Any patient event that is reported to any staff by patient, family member, other staff or any other person will be considered as POSSIBLE ABUSE if it meets any of the following criteria:			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A. Any indication of possible willful infliction of injury... C. Any patient or family complaint of physical harm, pain or mental anguish resulting from the activities of others... F. Any complaint of sexual harassment, sexual coercion or sexual assault... Protection Issues: A. Policy: Patients will be protected from harm during an investigation. B. Procedure: a. Any individual found to be in danger of injury would be removed from the source of the suspected abusive behavior. b. Medical and Emotional support will be made immediately available to any individual suffering suspected abused (sic)..." The immediate jeopardy that began on 8/10/11 was removed on 8/23/11 when the facility provided a plan of correction which addressed staff abuse training, inservices on abuse and resident's rights, protocol for staff and facility reporting of allegations of abuse, and a plan for monitoring staff awareness of facility			

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	155298	A. BUILDING 00 B. WING	08/26/2011

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	abuse policies and procedures, but the noncompliance remained at the lower scope and severity of isolated, no actual harm with the potential for more than minimal harm that is not immediate jeopardy, because resident assessments and staff evaluations for abuse policy knowledge had not been completed and a final abuse policy and procedure had not been completed. This federal tag relates to complaint IN00094823 and IN00095216. 3.1-27(a)(1) 3.1-27(a)(4) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of sexual abuse was thoroughly investigated, immediately reported to the administrator, reported to the State Agency, and ensure a	F0225	Element #1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.It is the policy of this facility to see that any allegation	09/25/2011

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	totally dependent resident (Resident B) was protected from further potential abuse (sexually inappropriate contact) by a facility volunteer (Volunteer #3). The facility failed to ensure facility staff (Activities Aid #1) promptly provided for resident safety and immediately reported a potentially abusive situation for 1 of 3 residents reviewed for allegations of abuse in a sample of 3. The facility also failed to fully investigate and report to the State Agency an allegation of staff (CNA #6) verbal abuse of a cognitively impaired, dependent resident (Resident I) for 1 of 2 residents reviewed for potential abuse in a supplemental sample of 6. Findings Include: The record of Resident B was reviewed on 8/16/11 at 3:00 p.m. Diagnoses included, but were not limited to, hypertension, seizure disorder, aphasia, anoxic brain injury, depression, coronary artery disease, and bipolar disorder. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/20/11 indicated Resident B was severely cognitively impaired and totally dependent on staff for bed mobility, locomotion, eating, and personal hygiene.		of abuse or any actual abuse is thoroughly investigated, immediately reported to the administrator and reported to the state agency. Further, any resident involved is to be protected immediately from any further abuse or further potential abuse. Additionally, all threats are to be immediately removed from the facility. This includes any person who may be suspected of alleged abuse.Element #2: How other residents having the potential to be affected by the same deficiency will be identified and what corrective action(s) will be taken.All residents have the potential to be affected by this finding. Following both of the afore mentioned instances of abuse or alleged abuse involving resident B and resident I, facility wide audits were conducted to be sure no other residents had experienced similar incidents that were not properly addressed. Now going forward, social services staff will monitor 10 residents per week (5 on each floor) to check for any unacceptable treatment or unkind words being used towards them. Any findings will be immediately reported to the administrator and all protocols will be followed as per facility policy and state and federal regulations. This monitoring will be ongoing.Element #3: What measures will be put into place or	

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	An untitled document received from the Administrator on 8/15/11 at 1:15 P.M. and identified as a recapitulation of events related to the investigation of an incident of potential abuse of Resident B on 8/10/11 indicated: "At approximately 1:15 PM on 8/10/2011 the Administrator was approached by (Name of Activity Director)...The Activity Director and her assistant told the Administrator that a resident (Resident C) had made gestures and pointed to indicate that something was wrong with (Resident C's) roommate... (Resident C) is alert and oriented to person and place, but confused to time (day, month, year). Speech is unclear, but able to answer yes/no questions. Able to understand others. Decision making is consistent and reasonable. At this time (Resident C) was trying to indicate through pointing and gestures about her roommate, and activity volunteer (Volunteer #3) walked by. (Name of Volunteer #3) walked by... As (Volunteer #3) walked by (Resident C) seemed to become more excited. She seemed to be indicating that her concern involved (Volunteer #3). (Resident C)		what systematic changes will be made to ensure that the deficient practice does not recur.At an all staff inservice held 9/20/2011 and 9/22/2011 the following was reviewed:A. Abuse 1. Abuse policy 2. Types of abuse 3. Step by step actions to be taken when a staff member observes or hears of an abuse or alleged abuse 4. Question/AnswersAny staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined up to and including termination. The facility has zero tolerance for abuse or failure to report abuse or alleged abuse.Element #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.At the monthly Quality Assurance meetings, any reports of abuse or alleged abuse will be reviewed to be certain all of the proper protocols are followed, including but not limited to, providing immediate safety to the resident, removing the threat and reporting to the administrator. Also, seeing all the proper investigation, interviewing of witnesses and reporting was done. Any concerns will be immediately addressed by the administrator.	

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	then placed her leg on her roommate (Resident B)...Since (Resident C) was linking (Volunteer #3) to (Resident B), (Activity Aid #1) went to get her supervisor to try to figure out what (Resident C) was trying to convey... When (Activity Aid #1's) supervisor arrived, they both took (Volunteer #3) aside and asked him if he had been near (Resident B) today. He said he had. They asked what type of interaction he had with (Resident B). (Volunteer#1) stated he was talking with her because she was crying and he wanted to comfort her. When asked what he had done to comfort her, he stated he kissed her on the cheeks and lips. He also stated he rubbed her thigh and her private area... When the Administrator interviewed (Volunteer #3) (he) admitted to kissing (Resident B's) cheeks, lips, and touching her thigh and private area...(Volunteer #3) was asked to stay seated and his aunt was called to pick him up...The allegations were explained to her...Administrator collected name badge, and key to sweet shop... The Administrator had advanced to (Resident B's) room...When asked by the Administrator if (Volunteer #3) had been inappropriate with her, she said 'yes.'			

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	When asked if (Volunteer #3) kissed or touched her, she said no he had not. She stated he had pushed her wheelchair too hard. (Resident B) was the assessed head to toe by the ADON (Assistant Director of Nursing) and Nurse Practitioner...the Nurse Practitioner asked her if (Volunteer #3) had touched her breast. She said 'yes'. When asked if he had touched her underneath her pants, she said 'Yes'. (Resident B) was sent to the ER for an exam and a rape kit. Her family was notified..." During an interview on 8/15/11 at 1:30 p.m., Activity Aid #1 indicated that during her communication with Resident C, which she indicated occurred at 11:50 a.m. in the 3rd floor dining room, she saw Volunteer #3 heading toward the pantry area, which is adjacent to the dining room.. She did not observe if he left the area. Residents B and C were sitting at the first table directly in front of the entrance to the dining room. This table is in clear view of the 3rd floor nurse's station. After determining that Resident C was communicating a concern involving Resident B and Volunteer #3, she then went to the activity director's office to report the incident. When she could not			

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	find the Activity Director she went to lunch. She indicated she did not inform anyone of the incident, and did not remove Resident B from the area where the incident occurred. She indicated she was uncertain where Volunteer #3 had gone. When she meet the Activity Director in the employee break room, she indicated she had something to tell her. At the Activity Director's request, she accompanied her to her car while the Activity Director got her lunch and described the incident. They then returned to the building. During an interview with the Activity Director on 8/15/11 at 3:00 p.m., she indicated Resident B had participated in an activity which ended at 11:50 a.m. She indicated nursing staff took Resident B to the dining room. She indicated Activity Aid #1 told her of the incident involving Volunteer #3 and Resident B at 12:45 p.m. She then found Volunteer #3 in the break room and took him to the lobby area of the facility to interview him. She indicated she could not confirm where Volunteer #3 was between the time of the incident and when she found him in the break room. After confirming the facts of the incident, she called the Administrator and met with him. He then isolated Volunteer #3 in his office. The Activity Director indicated the facility used			

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	"occasional" volunteers, which she indicated meant they volunteered less than 8 hours per week. She indicated these volunteers had no background checks done, no PPD records were required, and they received no training or instruction in facility policies, including abuse and resident's rights. She provided a list of 10 volunteers who met this criteria. During a telephone interview on 8/16/11 at 11:45 a.m., Volunteer #5 indicated he had been volunteering at the facility for 5 years, and came twice per week. He indicated he gave residents communion, read bible verses, and talked and prayed with the residents. He indicated he had never received any training or information about facility policy concerning resident rights or abuse protocols. He indicated he had not received any training of any kind from the facility. Volunteer #6 was interviewed by phone on 8/16/11 at 11:50 a.m. He indicated he had been volunteering for 5 years and came to the facility "all the time." He stated "They all know me so I don't need to sign in." On 8/15/11 at 1:15 p.m. the Administrator provided a packet of documents which he indicated to be the facility's complete records for Volunteer #3. There was a			

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	criminal background check dated 11/13/06 which was negative. There were 2 reference check forms which had not been completed. There was a 6 question "Abuse and Neglect Pre/Post Test" dated 5/04/09 which was signed as "Assisted by (Name of Activity Director)". There was no other indication of any training or education on resident's rights or abuse policies and protocols. During an interview with the Administrator on 8/16/11 at 3:20 p.m. he indicated he had originally believed the incident between Resident B and Volunteer#3 had occurred in the resident's room, but was later informed it had occurred in the dining room. He indicated he had not identified or interviewed any potential witnesses to the incident, including residents and staff who were in the area. He indicated he had not attempted to identify or interview any employees who might have been in the employee break room who could have identified what time Volunteer #3 arrived there. He indicated that because Volunteer #3 had confirmed the incident, he didn't think further investigation was warranted. 2. The record of Resident I was reviewed on 8/23/11 at 10:45 a.m. Diagnoses included, but were not limited			

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	to, chronic obstructive pulmonary disease, aspiration pneumonia, Alzheimer's Disease, congestive heart failure, hypertension, and depression. A quarterly Minimum Data Set (M.D.S.) assessment dated 7/07/11 indicated Resident I was cognitively impaired and required staff assistance with all activities of daily living. An untitled document received from the Administrator on 8/23/11 at 9:35 a.m. and identified as a recapitulation of his investigation of an allegation of staff verbal abuse of a resident indicated: On Thursday, 8/18/2011, at approximately 11:45 am, received a very strange voicemail...made an allegation about a CNA (first name of CNA #6)...The allegation was that (first name of CNA #6) had told a resident 'shut up white B...'...I asked (Social Services Director) to listen to the message...Approximately 11:50 a.m. (Social Services Director) and I went upstairs to find (CNA#6)...We were informed she was on lunch (erroneous information)...we checked to see where (Resident I) was located to ensure her safety...We then checked to see if she would be interviewable...(she) has a secondary diagnosis of Alzheimer's...we then interviewed (LPN #7)...she stated			

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	that...she did not work the previous day...We then asked (LPN #8)...the same question we asked (LPN #7)...(she) stated she did work, but did not receive any concerns involving either individual in question. She did state (CNA #6) was in the Savoy dining hall (with resident I)...11:57, asked (CNA #6) to join me, as I had some questions for her...I asked her if there were any type of negative interactions with any residents, to which she emphatically denied...In previous conversations with my Director of Nursing...she had shared (CNA #6) has had a history of being somewhat insubordinate and loud with her supervisors...At 12:02, I was done interviewing (CNA #6), so I gave her a few coupons to go stay in the break room until (Social Services #9) could speak with (Resident I)...Trying to identify more people to interview, I had (SS #9 and A.D.O.N. #10) listen to the message to see if they could recognize the voice. Nether of them could...As no one could identify anyone else to interview, and there were zero indications there was any validity to this random phone call, I returned the only person we could suspect of this back to work at about 12:31." The personnel file of CNA #6 was reviewed on 8/23/11 at 11:00 a.m. It included, but was not limited to:			

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An "Evaluation of Employee" form dated 5/22/11 indicated: "Remarks: Needs to modulate tone of voice at times perceived loud (symbol for "and") hostile.."

A "Notice of Disciplinary Action" form dated 6/07/11 indicated "This is to inform you that your performance and /or conduct has been recognized as described. This will become a part of your personnel file...loud verbally, inappropriate language (X 2 addressed)..."

During an interview on 8/22/11 at 4:00 p.m., the Administrator indicated that the allegation described above had not been reported to the State agency, that no additional investigation had been done, that there was no additional documentation of staff or resident interviews, and that CNA #6 continued to work in the facility.

During an interview with the Administrator on 8/25/11 at 10:45 p.m., he indicated that on further investigation of this incident the allegation of verbal abuse could not be disproven and that CNA #6 had been suspended with termination anticipated.

This federal tag relates to complaint IN00094823 and IN00095216.

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	3.1-28(c) 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure an allegation of sexual abuse of a totally dependent resident was immediately reported to the Administrator, reported to the State Agency, and fully investigated as required by law by not implementing facility policy and procedures related to investigating, reporting, and providing for resident protection following an allegation of abuse for 1 resident of 3 residents reviewed for allegations of abuse in a sample of 3. The facility also failed to implement facility policy and procedures related to investigating, reporting, and providing for resident protection following an allegation of abuse by not fully investigating and reporting to the State Agency an allegation of staff (CNA #6) verbal abuse of a cognitively impaired, dependent resident (Resident I), for 1 of 2 residents reviewed for potential abuse in a supplemental sample of 6.	F0226	Element #1: What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?It is the policy of this facility to see that all allegations of abuse or alleged abuse are immediately reported to the administrator, reported to the state agency and fully investigated as required by law and facility policy.Resident B is kept free from any type of abuse as stated above.Volunteer #3 is permanently banned from the facility and the facility property.Residents C and I are kept free from any type of abuse as stated above.Activity assistant #1 has been further educated, inserviced and counseled as to the axact steps that need to be taken immediately upon recieving of information or observing any action that even suggests the possibility of abuse or alleged abuse. This includes but is not limited to immediately providing for the residents safety removing any threat and reporting to the	09/25/2011

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	Findings Include: The record of Resident B was reviewed on 8/16/11 at 3:00 p.m. Diagnoses included, but were not limited to, hypertension, seizure disorder, aphasia, anoxic brain injury, depression, coronary artery disease, and bipolar disorder. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/20/11 indicated Resident B was severely cognitively impaired and totally dependent on staff for bed mobility, locomotion, eating, and personal hygiene. An untitled document received from the Administrator on 8/15/11 at 1:15 P.M. and identified as a recapitulation of events related to the investigation of an incident of potential abuse of Resident B on 8/10/11 indicated: "At approximately 1:15 PM on 8/10/2011 the Administrator was approached by (Name of Activity Director)...The Activity Director and her assistant told the Administrator that a resident (Resident C) had made gestures and pointed to indicate that something was wrong with (Resident C's) roommate... (Resident C) is alert and oriented to		administrator so all protocols can commence, including full assessment of the resident and reporting to all required parties. The resident's physician and family must be notified and consulted immediately. In addition, the appropriate state agency such as APS (Adult protective services), ombudsman, police, licensing or certification agencies will also be informed of abusive situations.CNA #6 no longer works at the facility. All incidents of abuse or alleged abuse are immediately reported to the administrator. All incidents are thoroughly investigated, including immediate interviews of any person(s) who might have a degree of knowledge of what has or may have happened (any potential witnesses). The administrator will spearhead this carrying out of protocol.The volunteer program is currently suspended pending revision, including photo ID requirements, sign-in/sign-out protocols, training, inservicing on abuse and resident rights, and reference checking.Element #2: How other residents having the potential to be affected by the same deficiency will be identified and what corrective action(s) will be taken.All residents have the potential to be affected by this finding. Following both of the afore mentioned instances of abuse or alleged abuse involving resident B and resident I, facility	

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	155298	A. BUILDING 00 B. WING	08/26/2011

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	person and place, but confused to time (day, month, year). Speech is unclear, but able to answer yes/no questions. Able to understand others. Decision making is consistent and reasonable. At this time (Resident C) was trying to indicate through pointing and gestures about her roommate, and activity volunteer (Volunteer #3) walked by. (Name of Volunteer #3) walked by... As (Volunteer #3) walked by (Resident C) seemed to become more excited. She seemed to be indicating that her concern involved (Volunteer #3). (Resident C) then placed her leg on her roommate (Resident B)...Since (Resident C) was linking (Volunteer #3) to (Resident B), (Activity Aid #1) went to get her supervisor to try to figure out what (Resident C) was trying to convey... When (Activity Aid #1's) supervisor arrived, they both took (Volunteer #3) aside and asked him if he had been near (Resident B) today. He said he had. They asked what type of interaction he had with (Resident B). (Volunteer#1) stated he was talking with her because she was crying and he wanted to comfort her. When asked what he had done to comfort her, he stated he kissed her on the cheeks and lips. He also stated he rubbed her thigh		wide audits were conducted to be sure no other residents had experienced similar incidents that were not properly addressed. Now going forward, social services staff will monitor 10 residents per week (5 on each floor) to check for any unacceptable treatment or unkind words being used towards them. Any findings will be immediately reported to the administrator and all protocols will be followed as per facility policy and state and federal regulations. This monitoring will be ongoing.Element #3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.At an all staff inservice held 9/20/2011 and 9/22/2011 the following was reviewed:A. Abuse 1. Abuse policy 2. Types of abuse 3. Step by step actions to be taken when a staff member observes or hears of an abuse or alleged abuse 4. Question/AnswersAny staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined up to and including termination. The facility has zero tolerance for abuse or failure to report abuse or alleged abuse.Element #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.At	

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	and her private area... When the Administrator interviewed (Volunteer #3) (he) admitted to kissing (Resident B's) cheeks, lips, and touching her thigh and private area...(Volunteer #3) was asked to stay seated and his aunt was called to pick him up...The allegations were explained to her...Administrator collected name badge, and key to sweet shop... The Administrator had advanced to (Resident B's) room...When asked by the Administrator if (Volunteer #3) had been inappropriate with her, she said 'yes.' When asked if (Volunteer #3) kissed or touched her, she said no he had not. She stated he had pushed her wheelchair too hard. (Resident B) was the assessed head to toe by the ADON (Assistant Director of Nursing) and Nurse Practitioner...the Nurse Practitioner asked her if (Volunteer #3) had touched her breast. She said 'yes'. When asked if he had touched her underneath her pants, she said 'Yes'. (Resident B) was sent to the ER for an exam and a rape kit. Her family was notified..." During an interview on 8/15/11 at 1:30		the monthly Quality Assurance meetings, any reports of abuse or alleged abuse will be reviewed to be certain all of the proper protocols are followed, including but not limited to, providing immediate safety to the resident, removing the threat and reporting to the administrator. Also, seeing all the proper investigation, interviewing of witnesses and reporting was done. Any concerns will be immediately addressed by the administrator.	

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	p.m., Activity Aid #1 indicated that during her communication with Resident C, which she indicated occurred at 11:50 a.m. in the 3rd floor dining room, she saw Volunteer #3 heading toward the pantry area, which is adjacent to the dining room.. She did not observe if he left the area. Residents B and C were sitting at the first table directly in front of the entrance to the dining room. This table is in clear view of the 3rd floor nurse's station. After determining that Resident C was communicating a concern involving Resident B and Volunteer #3, she then went to the activity director's office to report the incident. When she could not find the Activity Director she went to lunch. She indicated she did not inform anyone of the incident, and did not remove Resident B from the area where the incident occurred. She indicated she was uncertain where Volunteer #3 had gone. When she meet the Activity Director in the employee break room, she indicated she had something to tell her. At the Activity Director's request, she accompanied her to her car while the Activity Director got her lunch and described the incident. They then returned to the building. During an interview with the Activity Director on 8/15/11 at 3:00 p.m., she indicated Resident B had participated in			

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	an activity which ended at 11:50 a.m. She indicated nursing staff took Resident B to the dining room. She indicated Activity Aid #1 told her of the incident involving Volunteer #3 and Resident B at 12:45 p.m. She then found Volunteer #3 in the break room and took him to the lobby area of the facility to interview him. She indicated she could not confirm where Volunteer #3 was between the time of the incident and when she found him in the break room. After confirming the facts of the incident, she called the Administrator and met with him. He then isolated Volunteer #3 in his office. The Activity Director indicated the facility used "occasional" volunteers, which she indicated meant they volunteered less than 8 hours per week. She indicated these volunteers had no background checks done, no PPD records were required, and they received no training or instruction in facility policies, including abuse and resident's rights. She provided a list of 10 volunteers who met this criteria. During a telephone interview on 8/16/11 at 11:45 a.m., Volunteer #5 indicated he had been volunteering at the facility for 5 years, and came twice per week. He indicated he gave residents communion, read bible verses, and talked and prayed with the residents. He indicated he had never received any training or information			

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	about facility policy concerning resident rights or abuse protocols. He indicated he had not received any training of any kind from the facility. Volunteer #6 was interviewed by phone on 8/16/11 at 11:50 a.m. He indicated he had been volunteering for 5 years and came to the facility "all the time." He stated "They all know me so I don't need to sign in." On 8/15/11 at 1:15 p.m. the Administrator provided a packet of documents which he indicated to be the facility's complete records for Volunteer #3. There was a criminal background check dated 11/13/06 which was negative. There were 2 reference check forms which had not been completed. There was a 6 question "Abuse and Neglect Pre/Post Test" dated 5/04/09 which was signed as "Assisted by (Name of Activity Director)". There was no other indication of any training or education on resident's rights or abuse policies and protocols. During an interview with the Administrator on 8/16/11 at 3:20 p.m. he indicated he had originally believed the incident between Resident B and Volunteer#3 had occurred in the resident's room, but was later informed it had occurred in the dining room. He indicated			

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	he had not identified or interviewed any potential witnesses to the incident, including residents and staff who were in the area. He indicated he had not attempted to identify or interview any employees who might have been in the employee break room who could have identified what time Volunteer #3 arrived there. He indicated that because Volunteer #3 had confirmed the incident, he didn't think further investigation was warranted. 2. The record of Resident I was reviewed on 8/23/11 at 10:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, aspiration pneumonia, Alzheimer's Disease, congestive heart failure, hypertension, and depression. A quarterly Minimum Data Set (M.D.S.) assessment dated 7/07/11 indicated Resident I was cognitively impaired and required staff assistance with all activities of daily living. An untitled document received from the Administrator on 8/23/11 at 9:35 a.m. and identified as a recapitulation of his investigation of an allegation of staff verbal abuse of a resident indicated: On Thursday, 8/18/2011, at approximately			

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	11:45 am, received a very strange voicemail...made an allegation about a CNA (first name of CNA #6)...The allegation was that (first name of CNA#6) had told a resident 'shut up white B...'...I asked (Social Services Director) to listen to the message...Approximately 11:50 a.m. (Social Services Director) and I went upstairs to find (CNA #6)...We were informed she was on lunch (erroneous information)...we checked to see where (Resident I) was located to ensure her safety...We then checked to see if she would be interviewable...(she) has a secondary diagnosis of Alzheimer's...we then interviewed (LPN #7)...she stated that...she did not work the previous day...We then asked (LPN #8)...the same question we asked (LPN #7)...(she) stated she did work, but did not receive any concerns involving either individual in question. She did state (CNA #6) was in the Savoy dining hall (with resident I)...11:57, asked (CNA #6) to join me, as I had some questions for her...I asked her if there were any type of negative interactions with any residents, to which she emphatically denied...In previous conversations with my Director of Nursing...she had shared (CNA #6) has had a history of being somewhat insubordinate and loud with her supervisors...At 12:02, I was done interviewing (CNA #6), so I gave her a			

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	few coupons to go stay in the break room until (Social Services #9) could speak with (Resident I)...Trying to identify more people to interview, I had (SS #9 and A.D.O.N. #10) listen to the message to see if they could recognize the voice. Nether of them could...As no one could identify anyone else to interview, and there were zero indications there was any validity to this random phone call, I returned the only person we could suspect of this back to work at about 12:31." The personnel file of CNA #6 was reviewed on 8/23/11 at 11:00 a.m. It included, but was not limited to: An "Evaluation of Employee" form dated 5/22/11 indicated: "Remarks: Needs to modulate tone of voice at times perceived loud (symbol for "and") hostile.." A "Notice of Disciplinary Action" form dated 6/07/11 indicated "This is to inform you that your performance and /or conduct has been recognized as described. This will become a part of your personnel file...loud verbally, inappropriate language (X 2 addressed)..." During an interview on 8/22/11 at 4:00 p.m., the Administrator indicated that the allegation described above had not been reported to the State agency, that no			

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additional investigation had been done, that there was no additional documentation of staff or resident interviews, and that CNA #6 continued to work in the facility.

During an interview with the Administrator on 8/25/11 at 10:45 p.m., he indicated that on further investigation of this incident the allegation of verbal abuse could not be disproven and that CNA #6 had been suspended with termination anticipated.

An undated facility document titled "Volunteer Guidelines" received from the Administrator on 8/16/11 at 8:45 a.m. and identified as a current facility policy indicated:

"4. Abide by all 'Rules' and policies explained to you including Abuse Policy...

Don'ts: (sic) 1. Never have physical contact with a Resident other than minimal contact with hands as in manicure/card games/helping with writing."

An undated facility policy titled "Abuse Protection and Response Policy" received from the Administrator on 8/15/11 at 1:15 p.m. and identified as a current facility

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	policy indicated: "Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants and volunteers, family members or legal guardians, friends or any individual...The center administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority. Definitions: 1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish... 3. Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. 4. Sexual abuse: includes but is not limited to sexual harassment, sexual coercion, or sexual assault... Prevention issues: 1. Policy: the center will provide supervision and support services designed			

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	to reduce the likelihood of abusive behaviors... Identification Issues: A. Policy: Any patient event that is reported to any staff by patient, family member, other staff or any other person will be considered as POSSIBLE ABUSE if it meets any of the following criteria: A. Any indication of possible willful infliction of injury... C. Any patient or family complaint of physical harm, pain or mental anguish resulting from the activities of others... F. Any complaint of sexual harassment, sexual coercion or sexual assault... Protection Issues: A. Policy: Patients will be protected from harm during an investigation. B. Procedure: a. Any individual found to be in danger of injury would be removed from the source of the suspected abusive behavior. b. Medical and Emotional support will be made immediately available to any			

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	individual suffering suspected abused (sic)..." This federal tag relates to complaints IN00094823 and IN00095216. 3.1-28(a)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure health care plans were developed for a resident with an implanted medication delivery device (an intrathecal pump, a device for the continuous delivery of baclofen, an anti spasticity medication) and a resident (Resident G) who had a tracheotomy and was receiving supplemental oxygen therapy, for 1 resident of 3 reviewed for	F0279	Element #1: What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?It is the policy of this facility to develop care plans for each resident that address medical, nursing, mental and psychosocial needs. These concerns must have measurable goals and time tables and are based largely on assessment results.Currently, Resident G's	09/25/2011

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	care plans in a sample of 3 (Resident D) and 1 resident of 3 reviewed for care plans in a supplemental sample of 6. Findings include: 1. The record of Resident D was reviewed on 8/18/11 at 11:30 a.m. Diagnoses included, but were not limited to,traumatic brain injury, acute respiratory failure, quadriplegia, aphasia, and abnormal involuntary movements. A Quarterly Minimum Data Set (M.D.S.) assessment dated 7/27/11 indicated Resident D was severely cognitively impaired, was unable to communicate, and was dependent on staff for assistance with all activities of daily living. A "Resident Care Plan" for Resident D dated 4/21/11 indicated: "Concerns and Problems: Potential for problems R/T Dx (related to diagnosis): spastic quadriplegia. Resident Goals: Res. (resident) will be free from problems in the next 90 days. Approach/Plan: Medications as ordered (Baclofen pump)..."		care plan addresses their supplemental oxygen therapy.Element #2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All residents have the potential to be affected by this finding. A facility wide audit was done to see that all resident care plans are complete and timely. Also, all disciplines have updated their concerns and added measureable goals as needed. Going forward, the DON or designee will monitor 10 Care plans (5 on each floor) weekly to check for completeness and timliness, and measureable goals. Any concerns will be corrected upon discovery. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. After which, weekly checks will be done.Element #3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?At an all staff inservice held on 9/20/2011 and 9/22/2011, the following was covered:Care Plans A. Why have a care plan? B. Assessment based care plans C. What information goes on a care plan? D. Who writes a care plan? E. Who reads/uses a care plan? F. Why are goals measureable? G. When is a care plan reviewed? H. Who has	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A nurses's note dated 5/16/11 at 9:15 a.m. indicated "Res (resident) LOA (leave of absence) M.D. appt (appointment) for refill baclofen pump..." A physician's order dated 7/27/11 at 7:00 p.m. indicated in part "Baclofen 5 mg (milligrams) per GT (gastrostomy tube) Q8 (every 8 hours). A physician's order dated 7/27/11 at 7:15 p.m. indicated Clarification: D/C (discontinue) Baclofen 5 mg by GT resident has baclofen pump." Resident D's designated Power of Attorney (P.O.A.) was interviewed on 8/16/11 at 4:00 p.m. She indicated that on the evening of 7/27/11 she received a phone call from a facility nurse advising her that a new order had been written for Resident D to receive the medication baclofen 5 mg every 8 hours. She indicated she advised the caller that Resident D had an implanted baclofen pump, and that any additional administration of the medication could constitute an overdose. She indicated that the caller was unaware Resident D had a baclofen pump. During an interview with the Director of Nursing (D.O.N.) on 8/18/11 at 2:30 p.m. she indicated that an individual with a		input on a care plan? I. What are care plan meetings? Who goes? J. Resident families as related to care plans K. Questions/AnswersAny staff who fails to comply with the points of the inservice will be further educated and/or progressively disciplined.Element #4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?At the montlhy Quality Assurance meetings the results of the care plan monitoring by the DON/Designee will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored weekly by the administrator until resolution. NOTE: Any concerns will be addressed on the care plans at the time of discovery.	

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	155298	A. BUILDING 00 B. WING	08/26/2011

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	baclofen pump should not receive any supplemental baclofen and that the pump and medication should only be managed by the resident's neurologist. She indicated that there were risk inherent for patients with implanted devices such as the baclofen pump, including potentially serious consequences should residents with an implanted device be subject to diagnostic imaging such as an MRI (Magnetic Resonance Imaging) scan. She indicated at that time that Resident D had no health care plan indicating the presence of the baclofen pump with appropriate care and concern information. 2. The record of Resident G was reviewed on 8/22/11 at 9:00 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes mellitus, aphasia, hypertension, and benign prostatic hypertrophy. Nurse's notes for Resident G which indicated the use of supplemental oxygen therapy included, but were not limited to: 6/06/11 7:00 p.m. "...on 4 LPM (liters per minute) through secured trach (tracheotomy)..." 6/25/11 6:00 p.m. "...O2 (oxygen) (symbol for "at") 4 LPM per trach collar..."			

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	7/02/11 12:00 a.m. "...resident with O2 (symbol for "at") 4-6 LNC (liters by nasal cannula)..." 7/14/11 9:00 a.m. "...on O2 and continuous humidity..." 7/31/11 10:45 a.m. "...on O2 (symbol for "at") 6L (liters) via mask..." 8/08/11 11:00 p.m. "...Res (resident) (symbol for "with") O2 (symbol for "at") 4LNC..." 8/13/11 7:00 a.m. to 3:00 p.m.: "...O2 via trach mask (symbol for "at") 6L with 28% humidification..." 8/19/11 1:00 a.m. "...continues with O2(symbol for "at") 5 LPM with humidity..." Resident G's record was reviewed for care plans on 8/22/11 at 9:00 a.m. The record contained no care plan for the administration or monitoring of supplemental oxygen. During an interview with the Administrator, Vice President of Operations, and Director of Nursing (D.O.N.) on 8/25/11 at 10:45 a.m., the D.O.N indicated that a care plan for Resident G's supplemental oxygen had been written and placed in the resident's record on 8/19/11, and that prior to that date there had been no care plan for Resident G's use of supplemental oxygen. She indicated Resident G should have had			

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	a care plan for use of supplemental oxygen. 3. An undated facility document titled "Care Planning" received from the administrator on 8/18/11 at 3:50 p.m. indicated: "Policy: All residents will have a plan of care addressing the actual problems and potential problems...This plan of care will be a permanent part of the resident's record...The care plan should be comprehensive and include measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs..." This federal tag relates to complaint IN00095103. 3.1-35(a)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			

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	Based on record review and interview, the facility failed to ensure a resident (Resident G) who was receiving supplemental oxygen therapy had current physician's orders for the supplemental oxygen therapy for 1 resident of 6 reviewed for physician's orders in a supplemental sample of 6. Findings include: 1. The record of Resident G was reviewed on 8/22/11 at 9:00 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes mellitus, aphasia, hypertension, and benign prostatic hypertrophy. Nurse's notes for Resident G which indicated the use of supplemental oxygen therapy included, but were not limited to: 6/06/11 7:00 p.m. "...on 4 LPM (liters per minute) through secured trach (tracheotomy)..." 6/25/11 6:00 p.m. "...O2 (oxygen) (symbol for "at") 4 LPM per trach collar..." 7/02/11 12:00 a.m. "...resident with O2 (symbol for "at") 4-6 LNC (liters by nasal cannula)..." 7/14/11 9:00 a.m. "...on O2 and continuous humidity..."	F0514	Element #1: What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?It is the policy of this facility to see that all residents' clinical records are maintained in accordance with accepted professional standards and practices. Also, that they are complete, accurate, readily accessible, and organized.Resident G has a complete and specific order for supplemental oxygen.Element #2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by this finding. A facility wide audit was conducted to see that all meds, treatments, services, and care provided have an appropriate, acceptable order. Going forward, the DON/Designee will check 10 charts weekly (5 per floor) to see that all orders match all meds, treatments, services and care being provided in an appropriate and acceptable manner. The monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Afterwards, random weekly monitoring will occur.Element #3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	09/25/2011

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	verify all orders to be current and accurate at all times for all Residents. All orders are reviewed by licensed nurses monthly to verify the orders remain accurate month to month." This federal tag relates to complaint IN00095103. 3.1-50(a)(1)			